Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $33,495.29 for dates of service 04/19/02 and extending through 04/23/02.

   b. The request was received on 07/22/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. UB-92
   c. TWCC 62 form
   d. Medical Records
   e. SOAH decision
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/06/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/12/02. The response from the insurance carrier was received in the Division on 09/26/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 09/03/02

   "TWCC Rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the entire admission, after a Carrier audits a bill. See Tex. Admin. Code Section 133.401 (c). The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services which are not related to the compensable injury. At that time, if the total audited charges *for the entire admission* are below $40,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, if the total audited charges *for the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission.'… In accordance with the TWCC Rule 134.401 and QRL 01-01, the total amount of reimbursement due the hospital is $112,661.89. This amount is derived from the formula presented in 133.401(c)(6)(B),(C). Specifically, the audited charges "($150,215.86)-deducted charges (none per the EOB) x .75 = ($112,661.89.)[sic] The prior amounts paid by the carrier were $79,167.09. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of ($150,215.86-$79,167.09)= **$33,494.80, plus interest.**"

2. Respondent: Letter dated 09/26/02:

   "This dispute involves reimbursement for surgery on DOS 04/19/02 through 04/23/02; in short, it is a stop-loss category dispute. Carrier's position is aligned with that of…SOAH…It holds that the $40,000 stop-loss threshold applies to the 'audited charges'. The 'audited charges' are the gross bill after audit reductions as per rule plus carve outs (pharmacy in excess of $250 per dose and implantables) calculated at cost plus ten per cent. If 'audited charges' exceed $40,000.00, carriers pay 75% of 'audited charges' other than carve outs plus carve outs at cost plus ten per cent. Here, as can be seen by Carrier's EOB, Carrier used this methodology for computing the amount that ought to be paid and reduced the Provider's bill accordingly…."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service (dos) eligible for review are those commencing on 04/19/02 and extending through 04/23/02.

2. The Provider billed the Carrier $150,216.51 for the dos in dispute.

3. The Carrier made a total reimbursement of $79,167.09 for dos in dispute.

4. The amount left in dispute is $33,495.29, per the table of disputed services.

V. RATIONALE

Medical Review Division's rationale:
The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $150,216.51. Per Rule 134.401 (c)(6)(A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone); those not related to the compensable injury; or if an onsite audit is performed, those charges not documented as rendered during the admission.

The carrier is allowed to audit the hospital bill on a per line basis. In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for the implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, since the rule states this method is used only for the per diem reimbursement methodology.) There was no documentation submitted by the carrier to indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the hospital. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

However, review of the evidence from the provider reveals a difference in the number of items billed at various amounts (22 per the UB-92), the number of items in the invoice (24 per the invoice) and the number of items documented on the operative report. There is some correlation between the descriptions of items used in the operative report to the description of the items on the invoice. There is a description identifying some of the same items on the hospital's itemized statement. However, because of the inconsistencies in the documentation, and the large amount of mark up on the implantables, it is difficult to determine what the provider's usual and customary fees would be. Therefore, the Medical Review Division is unable to apply the stop-loss methodology to determine proper reimbursement for the documented implantables.

The above Findings and Decision are hereby issued this 27th day of March 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division
CO/co